“I Don’t Think We’re in Kansas Anymore…”

…the Brave New World of Medication-Assisted Treatment for Substance Use Disorders

Michael G Bricker MS, CADC-2, NCAC-II, LPC

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Michael G Bricker
MS, CADC-II, NCAC-II, LPC
Behavioral Health Clinician
Adult SUD Treatment Mgr.
Klamath Falls, OR
mbricker@lcsnw.org
Learning Objectives

1. Articulate the philosophical dialectic and practical considerations between "abstinence-based" and "medication-assisted" treatment modalities.

2. Identify the FDA/DEA-approved and experimental medications for assisting patients in recovery from alcohol, opioid and stimulant use disorders.

3. Become familiar with evidence based practices either designed for or adaptable for treating patients in recovery from alcohol, opioid and stimulant use disorders.
The Scope of the Problem

Heroin Use Trends: 2002 - 2013

SAMHSA - NSDUH 2014.

* Difference between this estimate and the 2013 estimate is statistically significant at the .05 level.
3,600 PEOPLE in the U.S.

STARTED MISUSING an opioid pain medication for the first time TODAY!
Figure 1: Heroin Deaths by Year, United States, 2009-2014
Heroin vs. Prescription Opioids

Drug dependence or abuse in the past year 2013*

- **heroin**
  - 517,000

- **prescription opioid pain relievers**
  - 1,900,000

*Note that the terms dependence and abuse as used in the NSDUH are based on the diagnostic categories used in DSM-IV; in the DSM-V, those categories have been replaced by a single Substance Use Disorder spectrum.

Source: National Survey on Drug Use and Health (NSDUH)
Scope of the Problem

Drug overdose is the leading cause of accidental death in the US, with 47,055 lethal drug overdoses in 2014. Opioid addiction is driving this epidemic, with 18,893 overdose deaths related to prescription pain relievers, and 10,574 overdose deaths related to heroin in 2014.

From 1999 to 2008, overdose death rates, sales and substance use disorder treatment admissions related to prescription pain relievers increased in parallel. The overdose death rate in 2008 was nearly four times the 1999 rate; sales of prescription pain relievers in 2010 were four times those in 1999, and the SUD admission rate was 6 times higher.

Fastest-growing demographic: 12 – 24 year olds!
The Scope of the Problem

Kilograms of opioids sold (per 10,000)

Deaths due to opioid overdose (per 100,000)

Admissions for opioid-abuse treatment (per 10,000)

National Vital Statistics System, 1999-2010; Automation of Reports and Consolidated Orders System of the DEA; Treatment Episode Data Set

Rx Opioid Trends: 1999-2010
2013 Overdose Deaths in the U.S.

- Heroin: 19%
- Prescription opioid pain relievers: 37%
- Drugs other than opioids: 44%

43,982 deaths from all drug overdoses in 2013

Source: National Center for Health Statistics at the CDC
Treatment Gap
Use of pain relievers or heroin in the past month 2012

28% ≈ 1.5 million opioid and heroin patients receiving medications *
72% ≈ 3.7 million no treatment received

5,197,000 total users surveyed

*Number of individuals receiving buprenorphine or naltrexone from IMS plus number of patients receiving methadone from NSSATS. Source: IMS Total Patient Tracker, September 2014 and SAMHSA NSSATS. Buprenorphine data exclude forms indicated for pain. Oral naltrexone factored for opioid dependence use. Methadone patients from SAMHSA, N-SSATS 2012.

REALITY CHECK

RATES OF OPIOID ABUSE/DEPENDENCY FAR EXCEED the maximum buprenorphine/methadone TREATMENT CAPACITY in nearly all states.
Why the need for Medication-Assisted Treatment?

NIH Effective Treatments for Opioid Addiction
Opiates and Opioids

- **Opiates** are present in opium e.g. morphine, codeine, thebaine (*codeine methylenol ether*)

- **Opioids** are manufactured as
  - Semi-synthetic opioids derived from an opiate (e.g. heroin from morphine)
  - Synthetics opioids completely synthesized to have function similar to natural opiates (e.g. methadone)
Opioid Pain Medications and Heroin are Chemically Similar and just as Addictive.
A Brief History of Opioid Treatment

- 1964: Methadone is approved.
- 1974: Narcotic Treatment Act limits methadone treatment to specifically licensed Opioid Treatment Programs (OTPs).
- 1984: Naltrexone is approved, but has continued to be rarely used (approved in 1994 for alcohol addiction).
- 1993: LAAM (long-acting methadone) is approved for non-pregnant patients only, but underutilized.
A Brief History of Opioid Treatment


• 2002: Tablet formulations of buprenorphine (Subutex®) and buprenorphine/naloxone (Suboxone®) were approved by the Food and Drug Administration (FDA).

• 2004: Sale and distribution of ORLAAM® is discontinued.
A Brief History of Opioid Treatment (con’t)

Jul 13, 2016 - Expansion of office-based treatment by allowing nurse practitioners and physician assistants to prescribe buprenorphine for opioid addiction. Authorization of grants to opioid treatment programs and practitioners who offer office-based medication-assisted treatment to expand access to naloxone through co-prescribing.

Feb 28, 2017 - Qualify for Nurse Practitioners (NPs) and Physician Assistants (PAs) Waiver. (PAs) can train and apply to become DATA-waiver practitioners. Nurse Practitioners and PAs need to complete 24 hours of training to be eligible for a prescribing waiver.

https://www.samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers

NOTE: Please ensure that your state regulations allow you to prescribe buprenorphine and other medications to treat OUD before you apply for the waiver. Some states may have overriding state legislation that will prevent NPs from prescribing these medications even if Federal law allows it. PA’s can only prescribe under a supervising waivered physician.
Medically Supervised Withdrawal
“Opioid Acute Detoxification”

- Low rates of retention in treatment
- High rates of relapse post-treatment
  - < 50% abstinent at 6 months
  - < 15% abstinent at 12 months
- “Detox” is not treatment, it is just the start of abstinence
- Increased rates of overdose due to decreased tolerance

O’Connor PG. JAMA. 2005.
Mattick RP, Hall WD. Lancet. 1996.
Reasons for Relapse

- Protracted abstinence syndrome (chronic withdrawal)
  - Generalized malaise, fatigue, insomnia
  - Poor tolerance to stress and pain (artificially lowered threshold)
  - ↑ Opioid craving
- Conditioned cues (triggers)
- Priming with small dose of drug

Opiate Reward Reinforcement

Reward/Reinforcement is in part controlled by mu receptors in the Reward Pathway:

- Ventral Tegmental Area (VTA)
- Nucleus Accumbens with projections to Prefrontal Cortex
- Dopaminergic system
DSM 5 Opioid Use Disorders

1. Tolerance
2. Withdrawal

Loss of Control
3. Larger amounts and/or longer periods
4. Inability to cut down on or control use
5. Increased time spent obtaining, using or recovering

6. Craving/Compulsion

Use Despite Negative Consequences
7. Role failure, work, home, school
8. Social, interpersonal problems
9. Reducing social, work, recreational activity
10. Physical hazards
11. Physical or psychological harm

1 Mild (2-3), F11.10
2 Moderate (4-5), severe (≥6) F11.20
2 Not valid if opioid taken as prescribed

APA (2013) Diagnostic and statistical manual of mental disorders (5th ed.)

ICD-10 F11.929 (eg. Chronic pain)
Opioid Tolerance & Physical Dependence

Both tolerance and physical dependence are physiological adaptations to chronic opioid exposure.

**Tolerance:**
- Increased dosage needed to produce specific effect
- Develops rapidly for CNS and respiratory depression

**Physical Dependence:**
- Signs and symptoms of withdrawal by abrupt opioid cessation, rapid dose reduction
Withdrawal Euphoria

Chronic use
Tolerance & Physical Dependence

Treatment of Opioid Use Disorder

Medication

Normal

Acute use

Episodic use

Opioid Agonist Therapy
methadone
buprenorphine
## Acute Opioid Withdrawal

<table>
<thead>
<tr>
<th>Grade</th>
<th>Symptoms / Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Anxiety, Drug Craving</td>
</tr>
<tr>
<td>1</td>
<td>Yawning, Sweating, Runny nose, Tearing eyes, Restlessness Insomnia</td>
</tr>
<tr>
<td>2</td>
<td>Dilated pupils, Gooseflesh, Muscle twitching &amp; shaking, Muscle &amp; Joint aches, Loss of appetite</td>
</tr>
<tr>
<td>3</td>
<td>Nausea, extreme restlessness, elevated blood pressure, Heart rate &gt; 100, Fever</td>
</tr>
<tr>
<td>4</td>
<td>Vomiting / dehydration, Diarrhea, Abdominal cramps, Curled-up body position</td>
</tr>
</tbody>
</table>

**Clinical Opiate Withdrawal Scale (COWS):**

- *pulse, sweating, restlessness & anxiety, pupil size, aches, runny nose & tearing, GI sx, tremor, yawning, gooseflesh*

- 5-12 mild, 13-24 moderate, 25-36 moderately severe, >36 severe
**COWS: Clinical Opioid Withdrawal Scale**

<table>
<thead>
<tr>
<th>Resting Pulse Rate:</th>
<th>GI Upset: over last 1/2 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measured after patient is sitting or lying for one minute</td>
<td></td>
</tr>
<tr>
<td>0 pulse rate 80 or below</td>
<td></td>
</tr>
<tr>
<td>1 pulse rate 81-100</td>
<td></td>
</tr>
<tr>
<td>2 pulse rate 101-120</td>
<td></td>
</tr>
<tr>
<td>4 pulse rate greater than 120</td>
<td></td>
</tr>
<tr>
<td>0 no GI symptoms</td>
<td></td>
</tr>
<tr>
<td>1 stomach cramps</td>
<td></td>
</tr>
<tr>
<td>2 nausea or loose stool</td>
<td></td>
</tr>
<tr>
<td>3 vomiting or diarrhea</td>
<td></td>
</tr>
<tr>
<td>5 multiple episodes of diarrhea or vomiting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: over past 1/2 hour not accounted for by room temperature or patient activity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 no report of chills or flushing</td>
</tr>
<tr>
<td>1 subjective report of chills or flushing</td>
</tr>
<tr>
<td>2 flushed or observable moistness on face</td>
</tr>
<tr>
<td>3 beads of sweat on brow or face</td>
</tr>
<tr>
<td>4 sweat streaming off face</td>
</tr>
<tr>
<td>0 no tremor</td>
</tr>
<tr>
<td>1 tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 slight tremor observable</td>
</tr>
<tr>
<td>4 gross tremor or muscle twitching</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness Observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 able to sit still</td>
</tr>
<tr>
<td>1 reports difficulty sitting still, but is able to do so</td>
</tr>
<tr>
<td>3 frequent shifting or extraneous movements of legs/arms</td>
</tr>
<tr>
<td>5 unable to sit still for more than a few seconds</td>
</tr>
<tr>
<td>0 no yawning</td>
</tr>
<tr>
<td>1 yawning once or twice during assessment</td>
</tr>
<tr>
<td>2 yawning three or more times during assessment</td>
</tr>
<tr>
<td>4 yawning several times/minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pupil size</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 pupils pinned or normal size for room light</td>
</tr>
<tr>
<td>1 pupils possibly larger than normal for room light</td>
</tr>
<tr>
<td>2 pupils moderately dilated</td>
</tr>
<tr>
<td>5 pupils so dilated that only the rim of the iris is visible</td>
</tr>
<tr>
<td>0 none</td>
</tr>
<tr>
<td>1 patient reports increasing irritability or anxiousness</td>
</tr>
<tr>
<td>2 patient obviously irritable or anxious</td>
</tr>
<tr>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone or Joint aches If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
</tr>
<tr>
<td>1 mild diffuse discomfort</td>
</tr>
<tr>
<td>2 patient reports severe diffuse aching of joints/muscles</td>
</tr>
<tr>
<td>4 patient is rubbing joints or muscles and is unable to sit still because of discomfort</td>
</tr>
<tr>
<td>0 skin is smooth</td>
</tr>
<tr>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>5 prominent piloerection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Runny nose or tearing Not accounted for by cold symptoms or allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 not present</td>
</tr>
<tr>
<td>1 nasal stuffiness or unusually moist eyes</td>
</tr>
<tr>
<td>2 nose running or tearing</td>
</tr>
<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
</tr>
<tr>
<td>Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety or Irritability</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 none</td>
</tr>
<tr>
<td>1 patient reports increasing irritability or anxiousness</td>
</tr>
<tr>
<td>2 patient obviously irritable or anxious</td>
</tr>
<tr>
<td>4 patient so irritable or anxious that participation in the assessment is difficult</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Gooseflesh skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 skin is smooth</td>
</tr>
<tr>
<td>3 piloerection of skin can be felt or hairs standing up on arms</td>
</tr>
<tr>
<td>5 prominent piloerection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>The total score is the sum of all 11 items</td>
</tr>
</tbody>
</table>

Initials of person completing assessment: _____________________
## Medically Supervised Withdrawal “Detox” using Buprenorphine

30 days*

<table>
<thead>
<tr>
<th>Study Day</th>
<th>Buprenorphine-Naloxone Dose mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4 + additional 4 as needed</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
</tr>
</tbody>
</table>

Withdrawal over 4-30 days is common in clinical practice. Buprenorphine is very flexible and withdrawal can be achieved rapidly or slowly, depending on treatment issues.

*Protocol Developed by NIDA Clinical Trials Network
Injectable Naltrexone - Vivitrol®

- Multicenter (13 sites in Russia) Funded by Alkermes
- DB RPCT, 24 wks, n=250 w/ opioid dependence
- XR-NTX vs placebo, all offered biweekly individual drug counseling
- Increased weeks of confirmed abstinence (90% vs 35%)
- Increased patients with confirmed abstinence (36% vs 23%)
- Decreased craving (-10 vs +0.7)


(No Black Box LFTs Warning Label for IM formulation)
Medications to Treat Opioid Use Disorder

- **Goals**
  - Alleviate signs/symptoms of physical withdrawal
  - Opioid receptor blockade
  - Diminish and alleviate drug craving
  - Normalize and stabilize perturbed brain neurochemistry

- **Options**
  - **Opioid Antagonist**
    - Naltrexone (full opioid antagonist)
  - **Opioid Agonist**
    - Methadone (full opioid agonist)
    - Buprenorphine (partial opioid agonist)
Buprenorphine Treatment: The Myths and The Facts
**MYTH #1: Patients are still addicted**

**FACT:** Addiction is *pathologic* use of a substance and *may* or *may not* include physical dependence.

- Physical dependence on a medication for treatment of a medical problem *does not* mean the person is engaging in pathologic use and other behaviors.
MYTH #2: Buprenorphine is simply a substitute for heroin or other opioids

**FACT:** Buprenorphine *is* a replacement medication; it is *not simply* a substitute

- Buprenorphine is a legally prescribed medication, not illegally obtained.
- Buprenorphine is a medication taken sublingually, a very safe route of administration.
- Buprenorphine allows the person to function normally.
MYTH #3: Providing medication alone is sufficient treatment for opioid addiction

FACT: Buprenorphine is an important treatment option. However, the complete treatment package must include other elements, as well.

✓ Combining pharmacotherapy with counseling and other ancillary services increases the likelihood of success.
MYTH #4: Patients are still getting high

FACT: When taken sublingually, buprenorphine is slower acting, and does not provide the same “rush” as heroin.

✓ Buprenorphine has a ceiling effect resulting in lowered experience of the euphoria felt at higher doses.
Studies (RCT) show buprenorphine more effective than placebo and equally effective to moderate doses (80 mg) of methadone on primary outcomes of:

- Abstinence from illicit opioid use
- Retention in treatment
- Decreased opioid craving

Oral Naltrexone Efficacy (opioid MAT)

- **Oral naltrexone**
  - Duration of action 24-48 hours
  - FDA approved 1984
    - 10 RCTs ~700 participants to naltrexone alone or with psychosocial therapy compared with psychosocial therapy alone or placebo
    - No clear benefit in treatment retention or relapse at follow up

- **Benefit in highly motivated patients**
  - Impaired physicians > 80% abstinence at 18 months
  - Close monitoring and frequent Urine drug screens
  - MUCH better research outcomes for alcohol

Cochrane Database of Systematic Reviews 2006
Buprenorphine Formulations

- **Sublingual forms** (tablets and films)
  - “Combo” (buprenorphine/naloxone)
  - “Mono” (buprenorphine only)
    - Approved for moderate to severe Opioid Use Disorders
    - Can be used OFF LABEL for pain

- **Parenteral and transdermal patch forms**
  - Approved for pain but **NOT** OUDs
  - Can not be used OFF LABEL for OUDs
Purpose of Naloxone in “combo”

- Naloxone has limited bio-availability by mouth or sublingual, but is active parenterally (e.g. injected subcutaneous, IM or IV)

- The combo product, if crushed, dissolved and injected the:
  - naloxone may cause initial withdrawal if the person is physically opioid-dependent.
  - decreasing diversion and misuse
  - naloxone will block, or attenuate, the opioid agonist effect of the buprenorphine
  - therefore safer if diverted

Buprenorphine/Naloxone Bioavailability

- If dissolved sublingually
  - Buprenorphine is active
  - Naloxone is not active

- If swallowed
  - Buprenorphine not active (minimal oral bioavailability)
  - Naloxone not active

- If injected
  - Buprenorphine active, but
  - Naloxone active x 20 minutes so attenuates the parenteral “rush”

- Not time-released so tablets/film strip can be split
Buprenorphine Safety

- Highly safe medication
  - for both acute and chronic dosing

- Primary side effects:
  - nausea and constipation (like other mu agonist opioids, but may be less severe and more self-limiting)

- No evidence of significant disruption in cognitive or psychomotor performance with buprenorphine maintenance

- No evidence of organ damage with chronic dosing of Buprenorphine “mono” or “combo”
Abuse Potential of Buprenorphine

- Euphoria in non-opioid dependent individuals
- Abuse potential less than full opioid agonists
- Abuse among opioid-dependent individuals is relatively low
- Combination product theoretically less likely to be abused by IV route
- Most illicit use is to prevent or treat withdrawal and cravings

Concurrent sedative-hypnotics?

Use or abuse of alcohol and other sedative-hypnotics are relative contraindications to buprenorphine

- Deaths have resulted from injecting buprenorphine and benzodiazepines
- Avoid alcohol while taking buprenorphine to avoid overdose

Identify and refer patients who are willing and able to undergo medically supervised withdrawal management from alcohol, benzodiazepines, or other sedatives

All best practices require frequent Urine Drug Screening for compliance

<table>
<thead>
<tr>
<th>Drug/Medication</th>
<th>Primary Metabolite</th>
<th>Ave. Detection Time (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiates (heroin, morphine)</td>
<td>Morphine</td>
<td>2-3</td>
</tr>
<tr>
<td>Semisynthetic Opioids (oxycodone, hydrocodone)</td>
<td>Variable Must be tested specifically</td>
<td>2-3</td>
</tr>
<tr>
<td>Methadone</td>
<td>EDDP</td>
<td>2-3</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Nor-buprenorphine</td>
<td>2-3</td>
</tr>
<tr>
<td>Cocaine</td>
<td>benzoylecgonine</td>
<td>2-3</td>
</tr>
<tr>
<td>Amphetamines</td>
<td></td>
<td>2-3</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>Varies by medication type</td>
<td>Variable with half life \ Unreliable immunoassays</td>
</tr>
<tr>
<td>Marijuana Occasional</td>
<td>THC</td>
<td>1-3 Up to 30</td>
</tr>
<tr>
<td>Marijuana Chronic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The “Bible”

The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use

AKA: The ASAM National Practice Guideline
1st to include all FDA-approved medications in single document
Definitions

- Opioid Use Disorder (OUD) is a chronic, relapsing disease defined in the DSM-5
- Bio-psycho-social-spiritual illness
- Addiction involving opioid use

All abbreviations and acronyms available in the ASAM National Practice Guideline
Before you begin… what are your biases?
BIOPSYCHOSOCIAL ASSESSMENT

- Identify and refer any acute medical or psychiatric needs
  - Physical exam & labs – LFTs, Hepatitis, HIV etc.
  - Pregnancy test & contraception queries

- Full Mental Health assessment

- Evaluation of past & present Substance Use
  - Poor prognosis with other SUDs
  - Tobacco use & cessation counseling

- Social & environmental factors
Diagnosis

- Provider confirms OUD diagnosis
- History & physical exam
- Scales measure OUD withdrawal symptoms
- Frequency of urine drug testing determined
ASAM National Practice Guideline
Treatment Setting

- Clinician & patient share treatment option decisions
- Consider patient preferences & treatment history & setting to determine medication
- Venue as important as medication selected
- Office treatment may not be suitable for patients with selected drug addiction issues
- OTPs offer daily dosing and supervision
Opioid Withdrawal Management

- Medications for withdrawal preferred to abrupt cessation
- Advise patients medications alone for opioid withdrawal not a complete treatment method
- Medical history & physical exam focus on withdrawal signs & symptoms
- Methadone withdrawal symptom management in OTP or inpatient setting
Opioid Withdrawal Management (cont’d)

- Buprenorphine can be used to manage withdrawal symptoms
- Combination buprenorphine & low dose oral naltrexone to manage withdrawal & facilitate ER injectable naltrexone shows promise
- Clonidine to support opioid withdrawal
- Anesthesia ultra-rapid opioid detoxification (UROD) is NOT recommended - too high risk
- Increased risk of OD or death with stopping agonist therapy & resuming opioid use
Buprenorphine

- Mild to moderate opioid withdrawal symptoms before buprenorphine
- Start with 2-4 mg; increase dosage in 2-4 mg increments
- Observe patients in office during induction, home inductions if experienced physician or patient
- After induction ≥8 mg a day; 4-8 mg increases w/ continued opioid use (daily dose 12-16 mg or higher)
- Psychosocial treatment with buprenorphine
Buprenorphine

- Reduce buprenorphine diversion
- Frequent urine drug tests (including buprenorphine)
- Frequent visits until stable
- If/when taper, should be slow & monitored
- 7-14 days between buprenorphine to naltrexone
- Buprenorphine to methadone no time delay
- No recommended time limit for treatment
Naltrexone

- Naltrexone rec to prevent relapse
- Psychosocial treatment with naltrexone
- Oral naltrexone taken daily in 50 mg doses or 3x weekly in two 100 mg doses, followed by one 150 mg dose
- Naltrexone ER administered every 4 weeks at set dosage of 380 mg/injection
- No recommended length of treatment
- Plan and monitor naltrexone to agonist switches
Psychosocial in Conjunction with Medications

- Recommended with any pharmacological treatment – at a minimum should include:
  - Psychosocial needs assessment
  - Supportive counseling
  - Links to existing family support
  - Referrals to community services
Psychosocial in Conjunction with Medications (cont’d)

- Collaboration with behavioral provider
- Psychosocial treatment generally recommended for patients receiving opioid agonist treatment
- Offered with oral and extended-release injectable naltrexone
## Medications for OUD Treatment

<table>
<thead>
<tr>
<th>Agent</th>
<th>Dose</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine sublingual film, tablets</td>
<td>PO: 2 mg, 8 mg film and tablets</td>
<td>Initial: 2–4 mg (Increase by 2–4 mg)</td>
</tr>
<tr>
<td>(generic)</td>
<td></td>
<td>Daily: ≥8 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Max: 24 mg/day</td>
</tr>
<tr>
<td>Methadone tablets/liquid</td>
<td>PO: 5 mg, 10 mg, tablets;</td>
<td>Initial: 10-30 mg (Reassess in 3–4 hours</td>
</tr>
<tr>
<td>(generic)</td>
<td>10 mg/mL liquid</td>
<td>add ≤10 mg PRN)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Daily: 60-120 mg¹</td>
</tr>
<tr>
<td>Naltrexone XR injection (Vivitrol®)</td>
<td>IV/IM: 380 mg in 4 cc</td>
<td>Every 4 weeks</td>
</tr>
<tr>
<td>Naltrexone tablets (generic)</td>
<td>PO: 50 mg</td>
<td>Daily: 50 mg (May give 2–3 daily doses at once on M–W–F.)</td>
</tr>
</tbody>
</table>

¹ Add 20 mg at 24 hours as needed.
ASAM National Practice Guideline

Pregnancy
Chronic pain
Adolescents
Psychiatric Disorders
Criminal Justice

Assessment
Diagnosis
Treatment
Special Populations
Pregnancy: Benefits of Opioid Agonist Therapy

Maternal Benefits

- 70% reduction in overdose related deaths
- Decrease in risk of HIV, HBV, HCV
- Increased engagement in prenatal care and recovery treatment

Fetal Benefits

- Reduces fluctuations in maternal opioid levels; reducing fetal stress
- Decrease in intrauterine fetal demise
- Decrease in intrauterine growth restriction
- Decrease in preterm delivery
Pregnant Women

- Identify & refer urgent medical conditions
- Medical & psychosocial examination
- OB/Gynecologists be alert to signs of OUD
- Psychosocial treatment is recommended
- HIV & hepatitis (B & C) testing & counseling
- With patient consent, urine testing for opioids and other drugs
- Treat OUD women w/methadone or buprenorphine rather than abstinence
Opioid Use Disorder and Breastfeeding

- The transfer of methadone and into human milk is minimal and unrelated to maternal doses
- Buprenorphine has poor oral bioavailability and is also compatible with breastfeeding
  - The amount of buprenorphine in human milk is small and unlikely to have negative effects on the infant
- Both are considered Category L3 (probably compatible)

Pregnant Women

- Co-managed w/ OB/GYN & addiction specialist
- Pregnancy affects pharmacokinetics
- Methadone treatment initiated ASAP
- Buprenorphine monotherapy is alternative to methadone
- Discontinue naltrexone if relapse risk low
- No naloxone unless overdose
- Breastfeeding encouraged with methadone and buprenorphine
Detoxification in pregnancy?

- Initial studies from 1970s demonstrated fetal distress and 5 fold increase in still birth rates with antepartum detoxification (Zuspan et al. 1975; Rementeria et al. 1973.)

- More recent data shows 2nd trimester detoxification can be safe for the fetus however maternal relapse rates prior to delivery range from 70-98% (Luty et al. 2003; Maas et al. 1990; Dashe et al. 1998.)

- Maintenance therapy in pregnancy has been shown to increase retention in prenatal care, addiction recovery and in-hospital deliveries (Jones et al. 2008.)
Important to differentiate between physiological dependence without dysfunction or active SUD – may suggest different EBP’s

### Individuals with Pain

- Correct diagnosis & target suitable for treatment identified
- Try non-narcotic medications first
- Consider methadone or buprenorphine for patients with active OUD not in treatment
- Pharmacotherapy with psychosocial counseling
- OUD methadone patients will require opioids in addition to regular methadone dose
- Methadone w/short-acting opioid for surgery
- Increase buprenorphine for mild acute pain
Physiological dependence without dysfunction: concentrate on pain management

Active SUD requires treatment emphasis

- Discontinue buprenorphine, start high potency opioid for severe acute pain
- Consult w/surgeon & anesthesiologist before discontinuing buprenorphine for surgery
- Treat naltrexone patients with mild pain NSAIDs and with ketorolac for severe pain
- Discontinue naltrexone 72 hours prior to surgery; ER naltrexone 30 days prior
Adolescents

- Consider all treatment options
- Opioid agonists, antagonists use appropriate
- Psychosocial treatment recommended
- Concurrent practices to reduce infection from STDs and blood-borne viruses
- Benefit from treatment in specialized facilities with multidimensional services
Opioid-Addicted Adolescents and Young Adults

Current treatment options for opioid-addicted adolescents and young adults are often unavailable and when found, clinicians report that the outcome leaves much to be desired.

States have different requirement for admitting clients under age 18 to addictions treatment. It is important to know the local requirements.
Opioid-Addicted Adolescents and Young Adults

Buprenorphine is approved for use with opioid dependent persons age 16 and older

Research conducted through the NIDA Clinical Trials Network (CTN 010) demonstrated that it can be safely and effectively used with young adults.

This research also indicated that medical treatment likely needs to be longer than current standard treatment indicates.
Use of Pharmacologic Treatment with Adolescents

- Pharmacologic therapy is recommended for all adolescents with severe opioid use disorder

- Buprenorphine is considered first line treatment
  - Most methadone clinics cannot admit patients under 18 years old, though methadone may be a good option for young adults with unstable living arrangements as daily visits provide structure and eliminate the need to manage medications at home
  - Naltrexone is also an option for adolescents and also may be clinically useful for adolescents/young adults living away from home, or patients with co-occurring alcohol use disorders
Co-Occurring Mental Disorders

- Comprehensive mental health status assessment to determine if stable
- Reduce, manage, & monitor suicide risk
- Ask about suicide ideation and behavior
- Assess psychiatric disorder at onset of agonist or antagonist treatment
- Pharmacotherapy + psychosocial treatment for OUD & co-occurring psychiatric disorder
Co-Occurring Mental Disorders

- Be aware of interactions between psychiatric medications and OUD
- Assertive Community Treatment (ACT) for schizophrenia and OUD w/history of hospitalization or homelessness
In Criminal Justice System

- Pharmacotherapy effective regardless of length of sentenced term
- Should get some type of pharmacotherapy and psychosocial treatment
- Opioid agonists and antagonists may be considered for treatment
- Pharmacotherapy initiated minimum 30 days prior to release
How To Get More Information

www.ASAMNationalGuideline.com

ASAM National Practice Guideline
The National Institute of Drug Abuse (NIDA) established the Methamphetamine Clinical Trials Group (MCTG) to conduct studies of medications for methamphetamine.

Paxil (Paroxetine or Pexeva)
Modafinil (Provigil®)
Mirtazapine (Remeron)
Naltrexone (ReVia® Vivitrol®)

www.addictionrecoveryguide.org/medication/methamphetamine

Source: University of California - Los Angeles May 19, 2015
Summary: The first study in the United States of Naltrexone's effect on methamphetamine users has found that this medication, approved by the US Food and Drug Administration for the treatment of alcoholism, is potentially a very promising treatment for methamphetamine addiction, researchers report.

NOTE: these are considered “off-label” uses
MAT and Pain Management

Common Misconceptions

• Maintenance opioid agonists provide pain relief.
• Use of opioids for pain relief may result in addiction or relapse
• Combining opioid analgesics and opioid agonist therapy may cause respiratory and central nervous system depression.
• The pain complaint may be a manipulation to obtain medications to feel “high.”
Buprenorphine and Pain Management

• Little clinical experience documented

• Acute Pain
  – Initially treat with non-opioid analgesics
  – Pain not relieved by non-opioid medications, follow usual pain management protocol

• Chronic Pain
  – May not be good candidate for buprenorphine treatment because of the ceiling effect
Medications approved to support abstinence from alcohol

Pharmacotherapy: Integrating New Tools into Practice

MAT for Alcohol

presented by

NAADAC
THE ASSOCIATION FOR ADDICTION PROFESSIONALS
www.naadac.org
### Transtheoretical Model and MAT

There are motivational strategies which are appropriate for each stage of change...

<table>
<thead>
<tr>
<th>What is the patient feeling/doing?</th>
<th>What can the counselor do?</th>
<th>Are medications appropriate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>not ready to change - the patient has little or no thought or interest in changing the behavior</td>
<td>raise ambivalence – increase the patient’s perception of risks and problems with current behavior</td>
<td>if the patient does not believe that they have a problem with alcohol then they probably will not be open to taking medication; however, knowing there are medications that could help may create an interest in treatment and offer hope</td>
</tr>
<tr>
<td>Contemplation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>thinking about change - the risks and benefits of change are assessed by the patient</td>
<td>tip the decisional balance — evoke reasons for change and risks of not changing; strengthen the patient’s self-efficacy for behavior change</td>
<td>could promote the consideration of possible sobriety and support the notion that change is possible; patients can view medications as another tool to help them achieve their goals</td>
</tr>
<tr>
<td>Preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>getting ready to make change - the patient gets ready to change and tests the waters by creating a plan of action</td>
<td>help the patient to determine the best course of action to take in seeking change; develop a plan</td>
<td>can be a part of a patient’s individualized treatment plan; schedule and regimen can promote the patient’s commitment to the plan and set a timeframe for initiating the plan</td>
</tr>
</tbody>
</table>
There are motivational strategies which are appropriate for each stage of change:

<table>
<thead>
<tr>
<th>Stage</th>
<th>What is the patient feeling/doing?</th>
<th>What can the counselor do?</th>
<th>Are medications appropriate?</th>
</tr>
</thead>
<tbody>
<tr>
<td>action</td>
<td>making the change—the patient makes steps to change</td>
<td>help the patient implement the plan; use skills; problem-solve; support self-efficacy</td>
<td>positive effects from medication can reinforce initial success of treatment; can reduce cravings and post-acute withdrawal symptoms</td>
</tr>
<tr>
<td>maintenance</td>
<td>sustaining the change—the patient continues the action plan until change has been integrated into the patient’s lifestyle</td>
<td>help the patient identify and use strategies to prevent relapse; resolve associated problems</td>
<td>can prevent relapse; can support stabilization and resolution of other problems during psychosocial therapy sessions; can reduce cravings and post-acute withdrawal symptoms</td>
</tr>
<tr>
<td>relapse</td>
<td>slipping back into previous behavior—the patient goes back to the behavior and must reenter the cycle of change</td>
<td>help the patient recycle through the stages of contemplation, preparation and action, without becoming stuck or demoralized because of relapse and identify the triggers leading to relapse</td>
<td>can support the patient’s commitment to change; can reduce cravings and post-acute withdrawal symptoms</td>
</tr>
</tbody>
</table>
Pharmacotherapies for Alcohol Dependence

There are currently four FDA-approved pharmacotherapies for alcohol dependence.

- **Antabuse** (disulfiram) - 1951
- **ReVia**/Depade (naltrexone) - 1994
- **Vivitrol** (naltrexone for extended-release injectable suspension) - 2004
- **Campral** (acamprosate) - 2006
Acamprosate General Facts

Generic Name: acamprosate calcium

Marketed As: Campral®

Purpose: encourages sobriety by reducing post-acute withdrawal symptoms from alcohol dependence

Indication: For the maintenance of abstinence from alcohol in patients with alcohol dependence who are abstinent at treatment initiation.

Year of FDA-Approval: 2004
How Does Acamprosate Work? (cont.)

- reduces glutamate activity by “monitoring” the amount of glutamate that can react at the NMDA receptors
- limits the amount of glutamate released by the neuron

\[ A = \text{acamprosate} \]

\[ \text{Glutamate} \]

Pre-Synaptic Neuron

Post-Synaptic Neuron

NMDA Receptor
**Results:** In all three studies, participants treated with acamprosate were able to maintain complete abstinence more frequently than those treated with placebo.\(^{54}\)
Disulfiram or Antabuse

Disulfiram General Facts

- **Generic Name:** disulfiram
- **Marketed As:** Antabuse®
- **Purpose:** Discourages drinking by making the patient physically sick when alcohol is consumed.
- **Indication:** An aid in the management of selected chronic alcohol patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage.
- **Year of FDA-Approval:** 1951

Scientific Research about Disulfiram (cont.)

**Results:** Participants treated with disulfiram did not maintain complete abstinence more frequently than those treated with placebo.66

**Graph:**

- **Complete Abstinence - Fuller et al. Study**
  - 250mg of disulfiram: 18.8%
  - 1mg of disulfiram: 22.5%
  - Placebo: 16.1%

**Note:** **not statistically significant**
Generic Name: naltrexone hydrochloride

Marketed As: ReVia® and Depade®

Purpose: To discourage drinking by decreasing the pleasurable effects experienced by consuming alcohol.

Indication: In the treatment of alcohol dependence and for the blockade of the effects of exogenous administered opioids.

Year of FDA-Approval: 1994
Naltrexone is an opioid receptor antagonist and blocks opioid receptors.

By blocking opioid receptors, the "reward" and acute reinforcing effects from dopamine are diminished, and alcohol consumption is reduced.
**Results:** In some instances, participants treated with naltrexone were able to maintain complete abstinence more frequently than those treated with placebo.⁷⁴
**Extended-Release Naltrexone General Facts**

Generic Name: naltrexone for extended-release injectable suspension

Marketed As: Vivitrol®

Purpose: To discourage drinking by decreasing the pleasurable effects experienced by consuming alcohol.

Indication: For the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment.

Year of FDA-Approval: 2006
Results: Participants treated with extended-release naltrexone did not maintain complete abstinence more frequently than those treated with placebo.**

** not statistically significant
**Results:** Participants treated with extended-release naltrexone had a greater reduction in the number of heavy drinking days during the entire study than those treated with placebo.\(^8^3\)
Module VI: Counseling Buprenorphine Patients
Areas of Needs Assessment
Opioid Drug use history
Alcohol & other drug use
Social Issues – strengths
Social Services – barriers?
Psychological history and status
Education – attainments & needs
Vocational – history & future goals
Counseling Buprenorphine Patients

Counselor Responses:
- Be flexible
- Don’t impose high expectations
- Don’t confront
- Be non-judgmental
- Use a motivational interviewing approach
- Provide support & reinforcement
Counseling Buprenorphine Patients

Address issues of the necessity of counseling with medication for recovery.

Recovery and Pharmacotherapy:

- Patients may have ambivalence regarding medication.
- The recovery community may ostracize patients taking medication.
- Counselors need to be aware of their biases, have accurate information and appropriate training.
Counseling Buprenorphine Patients

Issues in 12-Step Meetings:

Medication and the 12-Step programs

Program policy

“The AA Member: Medications and Other Drugs”
“We are not Doctors”

NA: “The ultimate responsibility for making medical decisions rests with each individual”

Some meetings are more accepting of medications than others
Counseling Buprenorphine Patients

A Motivational Interviewing Approach:
Dealing with other drugs and alcohol
Doing more than not-using

MIA-STEP
Developed through the Blending Initiative
Empirically supported mentoring products to enhance the MI skills of treatment providers
Provides tools to help supervisors offer structured, focused, and effective supervision.
The blending products are available at
www.drugabuse.gov/Blending  www.attcnetwork.org
Using Motivational Incentives

NIDA CTN research shows that treatment retention and drug abstinence are improved by providing low-cost reinforcement (prizes, vouchers, clinic privileges, etc.), for drug negative urine tests.

The Blending Product Promoting Awareness of Motivational Incentives (PAMI) provides information on this effective technique.

The blending products are available at:
www.drugabuse.gov/Blending  www.attcnetwork.org
Counseling Buprenorphine Patients

Relapse Prevention: Sample Topics

*Dangerous Emotions*
- Loneliness, anger, deprivation

*Be Smart, not Strong*
- Avoid the dangerous people and places
- Don’t rely on will power

*Avoiding Relapse Drift*
- Identify “mooring lines”
- Monitor drift
Pharmacotherapy alone is insufficient to treat drug addiction.

Prescribing Providers are responsible for providing or referring patients to counseling.

Contingencies should be established & agreed for patients who fail to follow through on referrals.
Patient Management: Treatment Monitoring

Goals for treatment should include:

No illicit opioid drug use
No other drug use or diversion
Absence of adverse medical effects
Absence of adverse behavioral effects
Responsible handling of medication
Adherence to treatment plan
A trigger is a stimulus which has been repeatedly associated with the preparation for, anticipation of, or use of drugs and/or alcohol. These stimuli include people, things, places, times of day, and emotional states.

(Center for Substance Abuse Treatment, 2006)
Issues in Recovery: Craving

A strong desire for something – limbic activation of “acquired drive state”

Does not always occur in a straightforward way

It takes effort to identify and stop a drug-use related thought.

The further the thoughts are allowed to go, the more likely the individual is to use drugs.

(Center for Substance Abuse Treatment, 2006)
Triggers & Cravings

During addiction, triggers, thoughts, and craving can run together. The usual sequence, however, is as follows:

The key to dealing with this process is to not allow for it to start. Stopping the thought when it first begins helps prevent it from building into a craving.

(Center for Substance Abuse Treatment, 2006)
However, the relapse process isn’t always linear.
Often, relapse can start innocently enough...

**Cognitive – Behavioral Relapse Process**

<table>
<thead>
<tr>
<th>Stages of Relapse</th>
<th>How do you do it?</th>
<th>What could you do instead?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Fleeting thoughts &amp; passing fancies”</td>
<td>Give some examples:</td>
<td></td>
</tr>
<tr>
<td>2. Feeding the fantasy: “an idle mind…” (remembering the “good times”, cognitive distortions, control fantasies – “this time it’ll be different”, “mental masturbation”, “drunk thinking &amp; peer influence”)</td>
<td>What’s YOUR fantasy?</td>
<td></td>
</tr>
<tr>
<td>3. Relapse rehearsal &amp; opinion reduction: (We began acting out the fantasies – setting ourselves up with old behaviors, resentment, withdrawing from support, etc.)</td>
<td>How can you recognize your excuses?</td>
<td></td>
</tr>
<tr>
<td>4. The “addictive click” – the acquired drive state: (Now we’re “jonesing” – the monkey is looking for the car keys)</td>
<td>How do you know when you’re on the edge?</td>
<td></td>
</tr>
<tr>
<td>5. The slip everybody else saw coming - “Sometimes you’re the windshield…sometimes you’re the bug!”</td>
<td>What do you tell yourself to make it “OK?”</td>
<td></td>
</tr>
<tr>
<td>6. The hangover, and Hobson’s Choice: “Would you rather be shot or hung?”</td>
<td>Physiological after-effects: guilty, shame &amp; remorse; discouragement, desensitization &amp; distress; waking up to discover that…</td>
<td>now you’ve only got two choices – keep on going, or try to stop. Not a good place to be… so don’t go there!</td>
</tr>
</tbody>
</table>

In your handouts – permission to reproduce
Thought-Stopping Techniques

- Visualization
- Snapping
- Relaxation
- Calling someone

(Center for Substance Abuse Treatment, 2006)
New Evidence-Based Practices for MAT

- Opioids: COR-12 (*Comprehensive Opioid Response with the 12 Steps - Hazelden*)
- Methamphetamine: STAGE - 12 (*NIDA Clinical Trials Network*)
- Chronic Pain (*opioid dependence w/o evidence of use disorder*): Illness Management and Recovery and Acceptance & Commitment Therapy (ACT)
May be more appropriate for chronic pain patients w/o evidence of “addiction” – there is no “expectation of abstinence”
The Model addresses chronic stressors, mental health and symptom mgmt. skills.
Common Questions

Q: Is STAGE-12 the same as AA?
A: No, STAGE-12 helps you understand how groups like AA, CA, and NA work and helps you be more actively involved in them to further your recovery.

Q: I’ve tried AA before but it didn’t work for me. How will STAGE-12 be different?
A: Your STAGE-12 counselor will help you look at your past recovery efforts and explore new ways to use 12-step groups to be more successful in the future.

Q: How long is the STAGE-12 study?
A: STAGE-12 takes place over 5-8 weeks; about the amount of time it takes to complete your outpatient treatment at this clinic. After the 5-8 week period we would like to see you again 3 and 6 months later to see how you are doing.

Q: I’m not religious. Can I still be part of the STAGE-12 study?
A: Yes. Wherever you are in your spiritual life, STAGE-12 will help you use that understanding to aid your recovery.

Q: I didn’t feel comfortable going to AA with my drug addiction. Can STAGE-12 help?
A: Yes. Your STAGE-12 counselors will help you find the groups that work best for you.

For more information
Please ask to speak with the study research staff. They can tell you more about the study and help you figure out if it would be right for you.

National Institute on Drug Abuse Clinical Trials Network
9001 Executive Boulevard
Room 3105, MSC 9067
Bethesda, Maryland 20892-9857
Telephone: (301) 443-6697
Fax: (301) 443-2317

06/15/06
CTN-0091
What is STAGE-12?

STAGE-12 is NOT the same as 12-step or AA. STAGE-12 breaks down how those programs work, making it easier for you to attend more meetings and to get the most out of them. STAGE-12 uses a combination of individual and group sessions, providing both one-on-one attention and a shared experience to help you better understand your addiction and take charge of your recovery.

What should I expect?

If you are selected for regular care, you will receive the usual clinical treatment, without STAGE-12. You will meet with your regular counselor and attend regular treatment groups. If you are in STAGE-12, you will have group and individual sessions built into your regular care at this clinic so you won’t attend extra treatment sessions. At the research visits, we will ask you about your drug use and about how you’re doing so we can determine how well STAGE-12 or regular care is working.

We want to know how you’re doing no matter how things are going. Our hope is that the information you provide about your own recovery experience in this study will help us design better tools for others seeking treatment in the future.

What if I want to join?

This study is for people 18 years or older who abuse or are dependent on stimulant drugs. You must be in treatment at this clinic and meet other characteristics for the study. If you choose to be in the study, you have a 50-50 chance of participating in STAGE-12 or in regular care at this clinic. You will be asked to attend research visits outside of treatment so we can see how you’re doing.

What is this study about?

Thank you for your interest in this study! We have put together this brochure to help you decide if the STAGE-12 study is right for you. STAGE-12 stands for Stimulant Abuser Groups to Engage in 12-Step.

This study seeks to find out if STAGE-12 can help people like you get off drugs and stay off drugs. STAGE-12 is for people who are addicted to stimulant drugs like cocaine, crack, or methamphetamine. STAGE-12 helps you understand how 12-step groups (like AA or NA) work and how to get started in them so you can be more successful in recovery.
Acceptance & Commitment Therapy for Chronic Pain

ACT helps patients to change their “relationship” with their pain using “radical acceptance” – completely compatible with MAT
The Hazelden Betty Ford Foundation’s Treatment Response to the Opioid Epidemic

Comprehensive Opioid Response with the Twelve Steps (COR-12)
46 opioid overdose deaths every day
The COR-12 Path to Lifelong Recovery

**RESIDENTIAL** (Structured)

**PHASE I**
1 - 3 Months

**PHASE II**
2 - 6 Months

**PHASE III**
7 - 18 Months

**PHASE IV**
18 Months and Ongoing

**MEDICATION**

**THERAPY**

**RECOVERY RESOURCES**

**TREND GAME**

**OPIOID SUPPORT GROUP**

**INDIVIDUAL & GROUP THERAPY**

**GROUP THERAPY**

**OPTIONAL GROUP THERAPY**

**MONITOR MEDICATIONS**

**POTENTIAL TAPER OR DISCONTINUE MEDICATIONS**

**DISCONTINUE MEDICATIONS**

**RESIDENTIAL PHASE I**
- Register for "MORE" (My Ongoing Recovery Experience)
- Learn about Hazelden Connection
- Intro to Alumni Services

**PHASE II**
- Consider/Care in Hazelden Connection
- Utilize "MORE" Modules and Content
- Engage Alumni Services

**PHASE III**
- Care and Engage in Hazelden Connection
- Continue actively working with "MORE" Modules and Content
- Continue to participate with Alumni Network
- Participate in a COR-12 Lodge experience at Harriet House Treatment Center

**PHASE IV**
- Continue to utilize Recovery Services
- Continue actively working with "MORE" Modules and Content
- Participate in a COR-12 Lodge experience at Harriet House Treatment Center

**Support in establishing active participation in Twelve Step groups**

**Support in transitioning to using Twelve Step group as primary support system**

**Twelve Step program as primary support system**
COR-12 Medication Pathways

Week 1 Options
Suboxone for withdrawal

Weeks 2–3 Options
Gradual taper
Optimize dose
Suboxone taper; Low dose oral naltrexone

Week 4 & Beyond Options
No medications
Suboxone
Extended-release naltrexone injection

Options increase patient choice and buy-in
Our Group Ground Rules

- **Come on Time**
  - Do not keep others waiting.
  - If you are more than fifteen minutes late, it will be considered an absence.

- **Be Present**
  - Participate.
  - Please turn off your cell phone.

- **Come Every Week**
  - Make a commitment to the group.
  - Call your group facilitator at least a day ahead if you won’t be able to make it.

- **Be Supportive of Each Other**

- **Be Constructive**
  - Avoid criticism; give constructive feedback.
  - Help each other find the good side of things.
  - Be caring and thoughtful.
  - Don’t put pressure on each other (no “shoulds”).

- **Give Equal Time for All**
  - Give everyone a chance to talk.
  - One person speaks at a time; no side conversations are allowed.

- **Keep it Practical**
  - Focus on solutions, not on the problems.

- **Practice What You Learn!**

- **Keep it Confidential**
  - Do not discuss personal things with people outside of the group.
  - “What is said in the group, stays in the group.”
  - For example, you can discuss what you are learning about depression with others, but do not talk about the other people who are in your group.

Hazelden Publishing
Isn’t this just another drug?

<table>
<thead>
<tr>
<th>Drug*</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>The motivation to use a drug is a brain reward (euphoria, or getting high).</td>
<td>The motivation to use medication is to prevent and treat an illness.</td>
</tr>
<tr>
<td>The pattern of using drugs is marked by dosages and methods of administration— such as injection or smoking—that create spikes and slumps in the drug’s concentration in a person’s blood. The dosage escalates and the drug is administered more frequently.</td>
<td>The pattern of using medication is marked by dosages, dosing schedules, and methods of administration that produce steady concentrations of the drug in a person’s blood.</td>
</tr>
<tr>
<td>Drug use is characterized by self-monitoring, a progressive loss of control, and secrecy and dishonesty.</td>
<td>Control and monitoring of medication is maintained via open, honest communication with physicians and family members.</td>
</tr>
<tr>
<td>The net effect of drug use is a progressive deterioration in the quality of life.</td>
<td>The net effect of medication use is a progressive improvement in the quality of life.</td>
</tr>
<tr>
<td>Drug use (other than alcohol use by adults) often involves breaking the law.</td>
<td>Medication is taken within laws that govern its manufacture, sale, possession, and use.</td>
</tr>
<tr>
<td>Drug use is often accompanied by other self-destructive and socially harmful behaviors.</td>
<td>Medication use is often accompanied by other health-promoting and recovery-enhancing behaviors.</td>
</tr>
<tr>
<td>Drug use often occurs within a drug-saturated social network.</td>
<td>Medication use occurs within a pro-recovery social network.</td>
</tr>
</tbody>
</table>
How Long Should Buprenorphine Maintenance Continue?

- No data to provide guidance on how long to treat a patient with buprenorphine/naloxone maintenance.
- Studies as long as 16 weeks show high relapse rates with medical withdrawal (Weiss et al., 2011).
- Patients can be retained long term; showed approximately 75% retention at one year with maintenance (Kakko et al., 2003).
- Continue maintenance as long as patient is benefitting from treatment (opioid/other drug use, employment, educational goals pursued, improvement in relationships, improvement in medical/mental illnesses, engaged in psychosocial treatment).
“How do I know that I’m ready to stop treatment?”

<table>
<thead>
<tr>
<th>Description</th>
<th>Progress Needed (DATE)</th>
<th>Making Good Progress (DATE)</th>
<th>Completed (DATE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAMHSA’s Four Elements of Recovery</strong></td>
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<tr>
<td>1. Health—is managing medical and mental health</td>
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<td>issues in a healthy way</td>
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<td>2. Home—is a stable and safe place to live</td>
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<td>3. Purpose—is meaningful daily activities, income,</td>
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<td>and resources</td>
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<td>4. Community—is relationships and a social</td>
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<tr>
<td>network that provides support, friendship,</td>
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<td>love, and hope</td>
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<tr>
<td>Stages of Change and ASAM Dimensions</td>
<td>Needs work</td>
<td>Progress</td>
<td>Complete</td>
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<td>-----------------------------------------------------------------------------------------------------</td>
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<tr>
<td>1. Evidence of behaviors consistent with the Action Stage across the ASAM dimensions</td>
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<td>2. The presence of action across dimensions for two months with a minimum amount of intervention</td>
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<td>3. Few intoxication/withdrawal issues</td>
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<td>4. Medical stability</td>
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<td>5. Stable and engaged from a mental health perspective</td>
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<td>6. Readiness to change behaviors (meetings, sponsorship, recovery engagement)</td>
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<td>7. Relapse prevention plan, third-party support /involvement, awareness about relapse issues</td>
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<td>8. Patient and third-party consultation on the person’s readiness for successful transition off Vivitrol or Suboxone medication</td>
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<td>9. Recovery environment stability, support network</td>
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<tr>
<td>Presence of Recovery Program Indicators</td>
<td>Needs work</td>
<td>Progress</td>
<td>Complete</td>
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<td>-------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>1. Has a strong routine for regular Twelve Step meetings</td>
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<td>2. Getting benefits from attending Twelve Step meetings</td>
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<td>3. Works effectively with a sponsor</td>
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<td>4. Has a strong connection to the recovery community</td>
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<td>5. Has a strong relapse prevention plan and skills</td>
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<td>6. Consistently demonstrates responsibility and accountability</td>
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<td>7. Displays emotional honesty and vulnerability</td>
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<tr>
<td>8. Practices daily spiritual principles and a connection with a Higher Power</td>
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</tbody>
</table>
Thank You!
Thank You for your interest and attention!

Michael G Bricker MS, CADC-II, LPC
Behavioral Health Clinician
Adult SUD Treatment Mgr.
Klamath Falls, OR
mbricker@lcsnw.org

LUTHERAN Community Services NORTHWEST
Michael G. Bricker MS, CADC-II, LPC

The STEMSS® Institute
Support Together for Emotional & Mental Serenity and Sobriety

Consultation in recovery from substance use and mental disorders

PO Box 1028
5341 Bryant Avenue
Klamath Falls OR 97601

Phone: (541) 880 - 8886
Email: mbricker6421@gmail.com

Promoting dual recovery since 1984